		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031708

Facility Name: TOULON REHAB & HCC

Address: BOX 249, HWY 17 EAST (Number) TOULON (City) 61483 (Zip Code)

County: STARK

Telephone Number: 309-286-2631 **Fax #** 309-286-4851

IDPA ID Number: 51-0271905

Date of Initial License for Current Owners: 12/1/1986

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ken Marx, BKD, LLP **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2003 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Junior Foster, THSCLLC, Mgt. Co for
(Title) TOULON REHAB & HCC

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	30,012	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	54	Intermediate (ICF)	54	19,764	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	136	TOTALS	136	49,776	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	Private Pay	Other	5 Total	
8	SNF	15,610	6,343	3,717	25,670	8
9	SNF/PED	0	0	0		9
10	ICF	9,747	5,099	0	14,846	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	25,357	11,442	3,717	40,516	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.40%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/18/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date ######## NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 82 and days of care provided 3,717

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number TOULON HCC # 31708 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	157,253	9,109	8,255	174,617		174,617	(3,565)	171,052			1
2	Food Purchase		175,358		175,358		175,358	(650)	174,708			2
3	Housekeeping		8,652	99,806	108,458		108,458		108,458			3
4	Laundry		13,520	67,215	80,735		80,735		80,735			4
5	Heat and Other Utilities			113,007	113,007		113,007		113,007			5
6	Maintenance	38,909	13,226	60,500	112,635		112,635		112,635			6
7	Other (specify):*			8,012	8,012		8,012		8,012			7
8	**TOTAL General Services**	196,162	219,865	356,795	772,822		772,822	(4,215)	768,607			8
	B. Health Care and Programs											
9	Medical Director			11,888	11,888		11,888		11,888			9
10	Nursing and Medical Records	1,510,309	52,469	10,540	1,573,318		1,573,318		1,573,318			10
10a	Therapy		2,396	127,846	130,242		130,242		130,242			10a
11	Activities	54,050	1,785	4,442	60,277		60,277		60,277			11
12	Social Services	74,925	90	2,535	77,550		77,550		77,550			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,639,284	56,740	157,251	1,853,275		1,853,275		1,853,275			16
	C. General Administration											
17	Administrative	65,504			65,504		65,504		65,504			17
18	Directors Fees											18
19	Professional Services			326,088	326,088		326,088	2,245	328,333			19
20	Dues, Fees, Subscriptions & Promotions			60,515	60,515		60,515	(41,048)	19,467			20
21	Clerical & General Office Expenses	98,451	21,573	75,761	195,785		195,785	(48,471)	147,314			21
22	Employee Benefits & Payroll Taxes			313,721	313,721		313,721	9,190	322,911			22
23	Inservice Training & Education			10,985	10,985		10,985	1,150	12,135			23
24	Travel and Seminar			1,657	1,657		1,657	4,742	6,399			24
25	Other Admin. Staff Transportation			13,780	13,780		13,780		13,780			25
26	Insurance-Prop.Liab.Malpractice			147,711	147,711		147,711		147,711			26
27	Other (specify):*											27
28	**TOTAL General Administration**	163,955	21,573	950,218	1,135,746		1,135,746	(72,192)	1,063,554			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,999,401	298,178	1,464,264	3,761,843		3,761,843	(76,407)	3,685,436			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number TOULON HCC #31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			198,879	198,879		198,879	17,093	215,972			30
31	Amortization of Pre-Op. & Org.			18,125	18,125		18,125	(18,125)	(0)			31
32	Interest			495,037	495,037		495,037	(8,039)	486,998			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,147	4,147		4,147		4,147			35
36	Other (specify):*											36
37	**TOTAL Ownership**			716,188	716,188		716,188	(9,071)	707,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,373	50,309	181,682		181,682		181,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,664	74,664		74,664		74,664			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		131,373	124,973	256,346		256,346		256,346			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,999,401	429,551	2,305,425	4,734,377		4,734,377	(85,478)	4,648,899			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,475)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,039)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(36)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(45,172)	21		24
25	Fund Raising, Advertising and Promotional	(41,048)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	12,051	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (85,719)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(18,125)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	18,366	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 241		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (85,478)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

TOULON HCC

ID# 31708

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (4,302)	21	1
2	Raw Foods Rebate	(650)	2	2
3	Adjust Depreciation Expense to Schedule XI	17,093	30	3
4	Vending Income	(90)	1	4
5	0	0	0	5
6	0	0	0	6
7	0	0	0	7
8	0	0	0	8
9	0	0	0	9
10	0	0	0	10
11	0	0	0	11
12	0	0	0	12
13	0	0	0	13
14	0	0	0	14
15	0	0	0	15
16	0	0	0	16
17	0	0	0	17
18	0	0	0	18
19	0	0	0	19
20	0	0	0	20
21	0	0	0	21
22	0	0	0	22
23	0	0	0	23
24	0	0	0	24
25	0	0	0	25
26	0	0	0	26
27	0	0	0	27
28	0	0	0	28
29	0	0	0	29
30	0	0	0	30
31	0	0	0	31
32	0	0	0	32
33	0	0	0	33
34	0	0	0	34
35	0	0	0	35
36	0	0	0	36
37	0	0	0	37
38	0	0	0	38
39	0	0	0	39
40	0	0	0	40
41	0	0	0	41
42	0	0	0	42
43	0	0	0	43
44	0	0	0	44
45	0	0	0	45
46	0	0	0	46
47	0	0	0	47
48	0	0	0	48
49	**Total**	12,051		49

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		See Attached Listings				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	Midamerica Care Foundation	100.00%	$ 0	$	1
2	V	19	Professional Services		Midamerica Care Foundation	100.00%	2,245	2,245	2
3	V	20	Due, Fees, Subscriptions & Promotions		Midamerica Care Foundation	100.00%	0		3
4	V	21	Clerical & Other General Office		Midamerica Care Foundation	100.00%	1,039	1,039	4
5	V	22	Employee Benefits		Midamerica Care Foundation	100.00%	9,190	9,190	5
6	V	24	Travel & Seminar		Midamerica Care Foundation	100.00%	1,150	1,150	6
7	V	26	Insurance		Midamerica Care Foundation	100.00%	4,742	4,742	7
8	V	0	0		0	0.00%			8
9	V	0	0		0	0.00%			9
10	V	0	0		0	0.00%			10
11	V	0	0		0	0.00%			11
12	V	0	0		0	0.00%			12
13	V	0	0		0	0.00%			13
14	Total			$			$ 18,366	$ * 18,366	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MidAmerica Care Foundation
Street Address: 7611 State Line Rd Ste 301
City / State / Zip Code: Kansas City, MO 64114
Phone Number: (816-444-0900
Fax Number: (0

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	eat and Other Utilities	Patient Days	241,015	8	0		40,516	$	1
2	19	Professional Services	Patient Days	241,015	8	13,353		40,516	0 2,245	2
3	20	s, Subscriptions & Promotions	Patient Days	241,015	8	0		40,516	0	3
4	21	al & Other General Office	Patient Days	241,015	8	6,180		40,516	0 1,039	4
5	22	Employee Benefits	Patient Days	241,015	8	54,667		40,516	0 9,190	5
6	24	Travel & Seminar	Patient Days	241,015	8	6,843		40,516	0 1,150	6
7	26	Insurance	Patient Days	241,015	8	28,208		40,516	0 4,742	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,251	$		$ 18,366	25

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Toulon Class 5H Bonds		X	Mortage	VARIES	12/1/1986	$ 3,700,000	5,387,386	12/1/2015	0.12	$ 495,037	1
2			X	W/C Constructions	Varies							2
3					Varies							3
4												4
5												5
	Working Capital											
6	Interest Income		X								(8,039)	6
7	H/O Interest Income											7
8												8
9	TOTAL Facility Related						$ 3,700,000	$ 5,387,386			$ 486,998	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,700,000	$ 5,387,386			$ 486,998	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TOULON HCC COUNTY STARK

FACILITY IDPH LICENSE NUMBER 31708

CONTACT PERSON REGARDING THIS REPORT Ken Marx, BKD, LLP

TELEPHONE 314-231-5544 FAX #: 314-231-9731

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,000 B. General Construction Type: Exterior BRICK & BLOCK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 489,873
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 18,125
4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	38,000		$ 9,100	1
2					2
3	TOTALS	38,000		$ 9,100	3

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	136		86	77	$ 3382107	$ 112,737	30	$ 112,737	$	$ 1,982,290	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements 1987			87	260,564	8,985	29	8,985		151,196	9
10	Improvements 1990			90	28,961	965	30	965		19,856	10
11	Improvements 1991			91	122,933		7			122,933	11
12	Improvements 1993			93	38,116		7			38,116	12
13	Improvements 1994			94	35,476	930	10	930		35,476	13
14	Improvements 1995			95	32,430	2,162	15	2,162		19,366	14
15	Improvements 1996			96	108,701	5,435	20	5,435		55,106	15
16	Improvements 1997			97	55,748	5,575	10	5,575		32,600	16
17	Wallpaper			98	6,902	690	10	690		4,198	17
18	Water Heater			98	3,703	247	15	247		1,564	18
19	Courtyard- Alzheimer			98	5,285	529	10	529		3,216	19
20	Carpet			99	785	118	5	118		785	20
21	Water Heater			98	3,471	347	10	347		1,967	21
22	Fence			98	3,471	434	8	434		2,423	22
23	Seal Parking Lot			99	5,354	446	12	446		2,268	23
24	3 Heat / AC Units			99	2,220	222	10	222		1,092	24
25	Carpet			99	733	147	5	147		672	25
26	Sprinkler Heads			2000	3,297	220	15	220		971	26
27	Water Heater			1999	3,700	247	15	247		1,131	27
28	Centrall Air Install			1998	1,623	162	10	162		973	28
29	Drapery / Valances			99	6,328	1,054	5	1,054		6,328	29
30	Trench Dig			2001	1,065	213	5	213		745	30
31	B-Hall Shower Room Remodel			2000	2,100	140	15	140		513	31
32	7-Wall Lanterns & 4 Chandeliers			2001	3,235	323	10	323		1,132	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Double Doors Kitchen	2001	$ 2,269	$ 151	15	$ 151	$	$ 504	37
38	Laundry Room Door	2001	1,456	97	15	97		315	38
39	Lighting, E-Wing Hall & Nurse Station	2001	3,364	224	15	224		729	39
40	Laundry Room #2 Door	2001	1,456	97	15	97		315	40
41	Building Purchase Settlement	2001	86,015	2,867	30	2,867		9,796	41
42	Carpet for Rm d-1	2001	995	142	7	142		438	42
43	Water Softner	2001	4,995	500	10	500		1,582	43
44	Install Water Heater/Piping / Vent / Wiring	2001	1,998	285	7	285		867	44
45	Water Lines	2001	2,424	346	7	346		1,052	45
46	Reinstall Central Air Unit	2001	1,050	150	7	150		450	46
47	Install THC Water Heater Piping Materials	2001	562	80	7	80		244	47
48	Auto Door Opener (Handicap)	2002	3,313	221	15	221		663	48
49	Parking Lot (Asphalt)	2002	7,000	583	12	583		1,701	49
50	Ceiling Tile Nurse Station	2002	1,240	124	10	124		351	50
51	Pipe Replacement (Fire Alarm)	2002	1,460	58	25	58		165	51
52	Replaced Locking System	2002	1,171	234	5	234		644	52
53	Architect Design	2002	80,205	4,010	20	4,010		11,028	53
54	Building Renovation 2001	2002	240,701	12,035	20	12,035		33,096	54
55	Parking Lot	2002	2,800	350	8	350		963	55
56	Restoring current sprinkler system on E Wing	2002	13,425	537	25	537		1,432	56
57	Landscaping Activity Court Yard	2002	2,817	282	10	282		751	57
58	Mansard Roof	2003	11,237	1,124	10	1,124		2,248	58
59	Phone System	2003	1,180	169	7	169		338	59
60	Wallcoverings	2003	1,362	272	5	272		544	60
61	Keypad & Timer Board	2003	2,051	410	5	410		820	61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,594,854	$ 167,676		$ 167,676	$	$ 2,557,953	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,594,854	$ 167,676		$ 167,676	$	$ 2,557,953	1
2	Wallpaper & Ceiling Tile	2003	$ 6772	$ 1354	5	$ 1354	$	$ 2708	2
3	Wages for Mike Croyle	2003	8979	1796	5	1796		3592	3
4	Laundry Room Remodel	2003	4907	245	20	245		490	4
5	Ventilation Tests	2003	3613	723	5	723		1446	5
6	Installation of commercial water heater	2003	4506	451	10	451		902	6
7	Convention Oven	2003	7805	780	10	780		780	7
8	52 Big Screen TV	2003	1515	152	10	152		152	8
9	Gear Box Reducer	2003	784	157	5	157		157	9
10	Heavy Duty Power Lifter	2003	3235	324	10	324		324	10
11	Dressing Cart 2qty	2003	1239	124	10	124		124	11
12	Stainless Steel Cuber	2003	1772	177	10	177		177	12
13	Privacy Curtains (310)	2003	10962	1566	7	1566		1566	13
14	Cocktail Table & Electric	2003	1550	310	5	310		310	14
15	Mill Conc OPI Oxygen	2003	3715	372	10	372		372	15
16	Vinyl Fence	2003	1379	92	10	138	46	138	16
17	Isolation valves	2003	1295	86	15	86		86	17
18	Re-piping of b-v	2003	16894	619	25	676	57	676	18
19	Demo 3 walls/	2003	1641	109	15	109		109	19
20	Water heater	2003	5462	319	10	546	227	546	20
21	100 gallon water	2004	3669	122	10	367	245	367	21
22	resident room	2004	1292	108	5	258	150	258	22
23	roof	2004	70057	1460	20	3503	2043	3503	23
24									24
25	2004 Depreciation Adjustment			-13732			13732		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	1
2									2
3									3
4									4
5									5
6									6
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,757,897	$ 165,390		$ 181,890	$ 16,500	$ 2,576,736	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 741,435	$ 22,114	$ 22,114	$	Various	$ 540,542	71
72	Current Year Purchases	28,337	4,868	4,868		Various	4,868	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 769,772	$ 26,982	$ 26,982	$		$ 545,410	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$ 35,499	$ 6,507	$ 7,100	$ 593	5	$ 35,499	76
77										77
78										78
79										79
80	TOTALS			$ 35,499	$ 6,507	$ 7,100	$ 593		$ 35,499	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,572,268	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 198,879	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 215,972	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 17,093	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,157,645	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 4,147 Description: See attached detail for rental expense
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 150

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$ 665	$ 9322	$	$ 9,987
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 665	$ 9,322	$	$ 9,987
10	SUM OF line 9, col. 1 and 2	(e)	$ 9,987			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	15

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	1,021	$ 51,088	$ 56	1,021	$ 51,144	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		431	18,580	0	431	18,580	2
3	Licensed Recreational Therapist		hrs		0	0	0			3
4	Licensed Physical Therapist	10a, 3	hrs		1,281	58,177	2,340	1,281	60,517	4
5	Physician Care	0	visits		0	0	0			5
6	Dental Care	0	visits		0	0	0			6
7	Work Related Program	0	hrs		0	0	0			7
8	Habilitation	0	hrs		0	0	0			8
9	Pharmacy		# of prescrpts		0	0	0			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	0	hrs		0	0	0			10
11	Academic Education	0	hrs		0	0	0			11
12	Exceptional Care Program	0			0	0	0			12
13	Other (specify):	0			0	0	0			13
14	TOTAL			$	2,733	$ 127,845	$ 2,396	2,733	$ 130,241	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number TOULON HCC # 31708 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 421,328	$	1
2	Cash-Patient Deposits	11,282		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	423,601		3
4	Supply Inventory (priced at)	11,488		4
5	Short-Term Investments			5
6	Prepaid Insurance	0		6
7	Other Prepaid Expenses	288		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 867,987	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	521,838		12
13	Land	9,100		13
14	Buildings, at Historical Cost	4,658,370		14
15	Leasehold Improvements, at Historical Cost	23,817		15
16	Equipment, at Historical Cost	769,772		16
17	Accumulated Depreciation (book methods)	(3,136,799)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	489,873		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(289,349)		20
21	Restricted Funds	44,161		21
22	Other Long-Term Assets (spe			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,090,783	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,958,770	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,479	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,282		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,631		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,829		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,278,275		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	45,673		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,513,169	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,387,386		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,387,386	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,900,555	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,941,785)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,958,770	$	48

***(See instructions.)**

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,646,036)	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow rollforward**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,646,035)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(295,750)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	0	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (295,750)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,941,785)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,184,370	1
2	Discounts and Allowances for all Levels	(328,173)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,856,197	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	331,678	6
7	Oxygen	3,525	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 335,203	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,565	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	190,096	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,436	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,705	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 258,802	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,039	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,039	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	(19,613)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (19,613)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,438,628	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	772,822	31
32	Health Care	1,853,275	32
33	General Administration	1,135,746	33
	B. Capital Expense		
34	Ownership	716,188	34
	C. Ancillary Expense		
35	Special Cost Centers	181,682	35
36	Provider Participation Fee	74,664	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,734,377	40
41	**Income before Income Taxes (line 30 minus line 40)****	(295,750)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (295,750)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Pending If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	7,400	7,504	$ 259,720	$ 34.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,029	7,137	155,986	21.86	3
4	Licensed Practical Nurses	20,797	20,985	379,083	18.06	4
5	Nurse Aides & Orderlies	69,040	69,504	651,404	9.37	5
6	Nurse Aide Trainees	3,976	4,044	44,534	11.01	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,069	6,388	54,050	8.46	10
11	Social Service Workers	5,622	5,726	74,925	13.09	11
12	Dietician	19,678	19,847	157,253	7.92	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,681	2,721	38,909	14.30	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,824	1,888	65,504	34.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	5,410	5,538	98,451	17.78	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,832	1,912	19,582	10.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,358	153,194	$ 1,999,401 *	$ 13.05	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	94	$ 8,255	1, 3	35
36	Medical Director	327	11,888	9, 3	36
37	Medical Records Consultant	26	1,600	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	87	6,399	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	2,435	11, 3	44
45	Social Service Consultant	40	2,535	12, 3	45
46	Other(specify) 0				46
47					47
48					48
49	TOTAL (lines 35 - 48)	613	$ 33,111		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TRACY OWENS	Admin.	0	$ 65,504
MARSHA JACOBS	Admin.	0	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,504

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type		Amount
Legal Fees	Various	0	$ 12,470
Purchased Service	Various		21,362
Data Processing	Various		7,600
Accounting	Various		9,580
Professional Services	Various		1,164
Management Fees	Various		265,911
Trustee Expense	Various		8,000
TOTAL (agree to Schedule V, line 19, column 3)			
(If total legal fees exceed $2500 attach copy of invoices.)			$ 326,088

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 112,637
Unemployment Compensation Insurance	0
FICA Taxes	165,297
Employee Health Insurance	19,348
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Other Benefits	16,438
	0
	0
Home Office Allocation	9,190
TOTAL (agree to Schedule V, line 22, col.8)	$ 322,911

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,527
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	9,940
Advertising & Public Relations	41,048
0	
0	
	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(41,048)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,467

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,657
Seminar Expense	0
Business Meals	
Home Office Allocation	4,742
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,399

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TOULON HCC # 31708 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **4284 - Illinois Health Care Assoc.**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **74,664**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,475**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, LLP KC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **In progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.